FRAMEWORK FOR STATE EVALUATION OF CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

(Developed by States, for States to meet requirements under Section 2108(b) of the Social Security Act)

State/Territory: North Carolina
(Name of State/Territory)

The following State Evaluation is submitted in compliance with Title XXI of the Social Security Act (Section 2108(b)).

_____
(Signature of Agency Head)

Date: _____

Reporting Period: October 1, 1998-September 30,1999

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SECTION 1. SUMMARY OF KEY ACCOMPLISHMENTS OF YOUR CHIP PROGRAM

This section is designed to highlight the key accomplishments of your CHIP program to date toward increasing the number of children with creditable health coverage (Section 2108(b)(1)(A)). This section also identifies strategic objectives, performance goals, and performance measures for the CHIP program(s), as well as progress and barriers toward meeting those goals. More detailed analysis of program effectiveness in reducing the number of uninsured low-income children is given in sections that follow.

1.1 What is the estimated baseline number of uncovered low-income children? Is this estimated baseline the same number submitted to HCFA in the 1998 annual report? If not, what estimate did you submit, and why is it different?

Our estimated baseline number of uninsured, low income (200% of federal poverty level or less) children is 126,461. This is not the estimate submitted to HCFA in our prior report. We decided to change the methodology used to calculate the number of uninsured children, and the baseline estimate reported here reflects the new methodology. We have changed our methodology to move away from using the CPS as the primary data source for determining the number of uninsured in North Carolina. We made this move for several reasons: 1) The CPS in North Carolina grossly undercounts the number of children in the Medicaid program. Our new methodology allows us to use actual Medicaid enrollment data. 2) The March 1999 CPS did not include a question on whether children had coverage under NC's Health Choice program. Therefore, we used actual Health Choice enrollment data. 3) Because of the small sample, the CPS was generating numbers that were clearly impossible. For example, according to the CPS there were 131,277 total children in the state who were under age 6 and had incomes at 100% of the federal poverty level or less. In fact, in the Medicaid program alone, there were 204,996 children in that same age and income bracket. In addition, although our original estimate was based on two-year averages of CPS data, when the CPS is used in our new methodology, three years are aggregated. We recognize that HCFA uses three-year averages, and we think that is a more appropriate use of the data, given the very small number of sampled children in our state. Also, the time for pulling Medicaid numbers was changed from a point-in-time in September to a lookback to the month of September in one year to the March of the next. In this manner, retroactive enrollments are also included in the total Medicaid count.

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1.1.1 What are the data source(s) and methodology used to make this estimate?

Data source and methodology used to make this estimate: The number of uninsured was estimated for children in 6 age/income cells—age was divided into two categories (less than 6 and 6-18 years old), and income was divided into three categories (less than or equal to 200% FPL, 201-300%, and greater than 300%). In each age category, the total number of children was based on 1997 data from the Office of State Planning. These numbers were distributed across the income cells within each age category based on the income distribution found in the combined 1995, 1996, and 1997 CPS. Subtracted from the total number of children was the actual number of Medicaid eligibles in the month of September 1997 (pulled from the DRIVE query in March 2000), and the estimated number of children covered by other, non-Medicaid sources of insurance. The remainder is our estimate of the number of uninsured. To estimate the number of children that were covered by non-Medicaid insurance, we took the percentage of non-Medicaid children in that age/income cell in the 1995,1996, and 1997 CPS who were covered by other forms of insurance, and applied that percentage to the total number of non-Medicaid children (based on actual Medicaid eligibles and OSP population numbers) in the cell.

Insurance Status of North Carolina Children, 1997-1999

	FFY 1999							
	LE 200%	%	201-300%	%	GT 300%		Sub Total	Total
<6 Medicaid	224,579	85.0%	203	0.2%	563	0.2%	225,346	36.4%
Health Choice	12,502	4.7%	3	0.0%			12,505	2.0%
Other insurance	16,014	6.1%	98,599	82.7%	221,854	94.3%	336,469	54.4%
Uninsured	11,000	4.2%	20,424	17.1%	12,862	5.5%	44287	7.2%
Total children	264,096	100.0%	119,230	100.0%	235,280	100.0%	618,607	100.0%
6-18 Medicaid	272,660	49.0%	82	0.0%	136	0.0%	272,878	20.4%
Health Choice	44,338	8.0%	7	0.0%	0	0.0%	44,345	3.3%
Other insurance	131,354	23.6%	207,609	82.7%	501,585	94.3%	840,549	62.8%
Uninsured	108,081	19.4%	43,339	17.3%	30,262	5.7%	181681	13.6%
Total children	556,432	100.0%	251,037	100.0%	531,983	100.0%	1,339,454	100.0%
Total Medicaid	497,239	60.6%	285	0.1%	699	0.1%	498,224	25.4%
Total Health Choice	56,840	6.9%	10	0.0%	0	0.0%	56,850	2.9%
Total other insurance	147,368	18.0%	306,208	82.7%	723,439	94.3%	1,177,017	60.1%
Total Uninsured	119,081	14.5%	63,763	17.2%	43,125	5.6%	225969	11.5%
Total children 0-18	820,528	100.0%	370,266	100.0%	767,263	100.0%	1,958,061	100.0%

	FFY 1997							
	LE 200%	%	201-300%	%	GT 300%		Total	%
<6 Medicaid	226,281	77.3%	68	0.1%	68	0.0%	226,418	37.0%
Other insurance	42,930	14.7%	99,878	84.8%	187,928	93.0%	330,737	54.0%
Uninsured	23,361	8.0%	17,903	15.2%	14,058	7.0%	55322	9.0%
Total children	292,572	100.0%	117,849	100.0%	202,054	100.0%	612,477	100.0%
6-18 Medicaid	264,789	51.6%	26	0.0%	54	0.0%	264,870	20.6%
Other insurance	145,274	28.3%	198,220	84.0%	510,938	94.8%	854,432	66.3%
Uninsured	103,100	20.1%	37,840	16.0%	28,140	5.2%	169080	13.1%
Total children	513,162	100.0%	236,086	100.0%	539,131	100.0%	1,288,382	100.0%
Total Medicaid	491070	60.9%	94	0.0%	122	0.0%	491286	25.8%
Total other insurance	188204	23.4%	298098	84.2%	698865	94.3%	1185167	62.3%
Total Uninsured	126461	15.7%	55743	15.7%	42198	5.7%	224402	11.8%
Total children	805735	100.0%	353935	100.0%	741185	100.0%	1900855	100.0%

1.1.2 What is the State's assessment of the reliability of the baseline estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

With our revised methodology, we know the Medicaid numbers to be true, and have high confidence in the accuracy of the population estimates from the Office of State Planning. Unfortunately, the estimate of the number of uninsured children also relies on the CPS estimate of the number of children with coverage by non-Medicaid forms of insurance. Because of the problems with the CPS discussed on 1.1, we do not have complete confidence in the accuracy of these estimates, but at this time do not have an alternative source of data.

1.2 How much progress has been made in increasing the number of children with creditable health coverage (for example, changes in uninsured rates, Title XXI enrollment levels, estimates of children enrolled in Medicaid as a result of Title XXI outreach, anti-crowd-out efforts)? How many more children have creditable coverage following the implementation of Title XXI? (Section 2108(b)(1)(A))

North Carolina has made considerable progress in increasing the number of children with creditable health coverage. Between 1997 and 1999, there has been a 7,380 reduction in the raw number of low income uninsured children under age 18. Without the state's recent efforts to expand health insurance coverage for low income children, there would likely have been an increase in the number of uninsured children. Between 1997 and 1999, for example, the percentage of uninsured children with incomes between 201-300% of the federal poverty guidelines increased from 15.7% to 17.2%. If the percentage of uninsured for children with incomes below 200% of the federal poverty guidelines had followed these same trends, we would have anticipated that there would have been 141,623 uninsured children in 1999 (or 22,542 more than we estimate). However, we could reasonably have anticipated a larger increase in the uninsured among lower income families, as they have historically have had the greatest risk of being uninsured.

The gains have almost all been through the NC Health Choice program. Between 1997 and 1999, the overall percentage of low income children birth through age 18 who received Medicaid remained constant (approximately 61%). At the same time, the percentage of children with other health insurance coverage dropped (from 23.4% in 1997 to 18.0% in 1999). NC also experienced a decrease in the percentage of children with other health insurance coverage for children with family incomes between 201-300% of the federal poverty guidelines (from 84.2% in 1997 to 82.7% in 1999). A study conducted by the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill estimates that very little of the drop in private health insurance coverage among low income families was due to the crowd-out effect (see answer to question 3.6.2). Based on their study, it is reasonable to assume that all or almost all of the 56,840 children covered by NC Health Choice in September 1999 would have been uninsured but for the Health Choice program.

1.2.1 What are the data source(s) and methodology used to make this estimate?

Data source and methodology used to make this estimate: The methodology used to generate the estimate of 1999 number of uninsured children was the same as the new methodology for 1997 reported in 1.1.1, except that actual NC Health Choice enrollment numbers were added into the calculations. The number of uninsured was estimated for children in 6 age/income cells—age was divided into two categories (less than 6 and 6-18 years old), and income was divided into three categories (less than or equal to 200% FPL, 201-300%, and greater than 300%). In each age category, the total number of children was based on 1999 population estimate from the Office of State Planning. These numbers were distributed across the income cells within each age category based on the income distribution found in the combined 1997, 1998, and 1999 CPS. We subtracted: 1) the actual number of Medicaid eligibles in the month of September 1999 (pulled from the DRIVE query in March 2000), 2) the actual number of NC Health Choice eligibles in the month of September 1999 (pulled from the DRIVE query in March 2000), and 3) the estimated number of children covered by other, non-Medicaid sources of insurance. The remainder is our estimate of the number of uninsured. To estimate the number of children that were covered by non-Medicaid insurance, we took the percentage of non-Medicaid children in that age/income cell in the 1997,1998, and 1999 CPS who were covered by other forms of insurance, and applied that percentage to the total number of non-Medicaid, non-Health Choice children (based on actual Medicaid and NC Health Choice eligibles and OSP population numbers) in the cell.

1.2.2 What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

See the answer to 1.1.2

1.3 What progress has been made to achieve the State's strategic objectives and performance goals for its CHIP program(s)?

Please complete Table 1.3 to summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in the Title XXI State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List the State's strategic objectives for the CHIP program, as specified in the State Plan.

Column 2: List the performance goals for each strategic objective.

Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, denominator). Please attach additional narrative if necessary.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
To reduce the number of uninsured children living in families with incomes below 200% of the federal poverty guidelines	The number of uninsured children in families with incomes below 200% of the federal poverty line will be reduced by 35,000 children in the first year of operation	Data Sources: NC Health Choice enrollment data . Methodology: Actual NC Health Choice enrollment numbers Numerator: NA Denominator: NA Progress Summary: There were 56,850 children who were eligible for NC Health Choice in September 1999. Most of these children would have been uninsured, but for the creation of the NC Health Choice program. See questions 1.2.1 and 3.6.2 (the question addressing crowd-out).
OBJECTIVES RELATED TO CHIP ENROLLMENT		
To simplify eligibility intake process for both Title XXI and Title XIX children's programs.	At least 50% of the Title XXI applications will occur through mail in or at non-traditional sites in the first year	Data Sources: Eligibility Information System NC Health Choice/Medicaid approved applications by source Methodology: Applications are coded according to the source of the application. There are three categories: traditional DSS office, non-traditional mail in application and county health department application. Numerator: number of applications received through health departments and by mail 14,378 cases* Denominator: total 40,467 cases* Progress Summary: 35% of the NCHC applications occurred through non-traditional sources. Expectations are that as those above 150% FPL increase participation in the program, the rate of applications through non-traditional sources will grow. (average children per case 1.5)

OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT		
To increase Medicaid enrollment	CHIP outreach will attract more children to the Medicaid program.	Data Sources: September 1997 and 1999 Medicaid enrollment data (from DRIVE) Methodology: Percentage of Medicaid eligibles below 200% of FPG was calculated by taking actual Medicaid enrollment figures by age for September 1997 and 1999, and dividing it by state population estimates for children with the same income and age. In each age category, the total number of children was based on 1997 or 1999 population estimate from the Office of State Planning. These numbers were distributed across the income cells within each age category based on the income distribution found in combined three-year average CPS distribution (1997: 1995-1997; 1999: 1997-1999). Numerator: 1999: 224,579 (<6) 272,660 (6-18) 497,239 (total <19) 1997: 226,281 (<6) 264,789 (6-18) 491,070 (total <19) Denominator: 1999: 264,096 (<6) 556,432 (6-18) 820,528 (total <19) 1997: 292,572 (<6) 513,162 (6-18) 805,735 (total <19) Progress Summary: The total number of Medicaid eligible children increased between 1997 and 1999 from 491,070 (1997) to 497,239 (1999), although the percentage of low income children (<200% FPL) remained relatively constant (61%). North Carolina showed an increase in the percentage of younger children under age 6 covered by Medicaid (from 77.3% in 1997 to 85.0% in 1999), but a slight decrease in the percentage of older children ages 6-18 (from 51.6% in 1997 to 60.6% in 1999). The numbers of Medicaid children in our Medically Indigent Children (SOBRA) program went up from 231,891 in October 1998 to 281,373 in October, 1999, an increase of 49,482 children. During the same time period, the children on TANF went down from 110,976 (under 21) in October of

		1998. By October 1999 the number on TANF under 21 was 86,759 for a loss of 24,117. North Carolina recently made two policy changes to try to increase the number of children covered through Medicaid: 1) 12-month continuous Medicaid eligibility for children, which started being phased-in in February, 1999 and applied to all children who become eligible for Medicaid after that date; and 2) 24-month transitional eligibility for families that lose TANF due to work earnings. This latter change, which is targeted to former TANF families began in October 1999 (after we measured the 1999 Medicaid child enrollment numbers).
OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)		
To increase awareness of health care coverage options through an outreach campaign	Fully implement Outreach Plan as outlined in S-CHIP Plan	Data Sources: The S-CHIP plan Methodology: Examine the list and check off those things that are completed, need to be completed or have since been rejected as unnecessary based on the consensus of the statewide outreach committee. Examine the impact on enrollments on a county by county basis. Numerator: County-by County enrollment numbers Denominator:: County by County population targets Progress Summary: The first year of work, using local coalitions and targeting families being served in means tested programs has been very successful. Our second year will focus on efforts to bring in more in the business community. At the end of the first year, 58 of the 100 counties were at or above the state average of 71percent of total projected eligible population enrolled. County ranges were from a high of 176% in a small, rural eastern county to a low of 38% in a small, rural Piedmont county. Only four counties enrolled fewer than 50% of their estimated eligible population. 18 counties enrolled more than 100% of their estimated eligible population. (see attachments)

OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)		
To encourage utilization of preventive health care services To increase child health screenings among enrolled children	The average number of visits per enrolled child will equal or exceed Title XIX rates At least 50% of enrolled Title XXI children will be screened in the first year with 80 percent of enrollees screened in five years.	Data Sources: The Title XIX participation rate in preventive health services for North Carolina is 54% according to the HCFA 416 for ffy 1998. Methodology: Numerator: Denominator: Progress Summary: It is not yet possible to measure accurately the rate of preventive screenings under Health Choice, nor to make comparisons with Medicaid for at least two reasons. (1) Because Health Choice uses the Blue Cross CPT coding system, there is no single, distinct code for screening as there is for Medicaid. Thus, there is under-reporting under Health Choice. In addition, if a child comes in with a problem under Health Choice, the provider is likely to code a "sick" visit, even though the criteria of a preventive screen were met. Thus, an additional source of under-reporting. (2) With only one year's experience and dramatically increasing enrollment during the year, it is not yet possible to determine accurately the number of children in the screening target. Indeed, the largest percentage of children in Health Choice are in age groups that are not scheduled to be screened annually. Thus, we need another year's experience to create a more accurate "denominator". Nevertheless, it is clear that maintaining a high preventive screening rate under Health Choice will be more difficult than for Medicaid. The latter program uses a PCCM delivery system, has a statewide reminder system, and utilization enhancement staff (Health Check Coordinators) in most areas of the state. Health Choice has none of these. A periodic newsletter to families encouraging the use of preventive care is under consideration. enrollees urging them to get preventive health visits.

OTHER OBJECTIVES		
		Data Sources: Methodology: Numerator: Denominator: Progress Summary:

SECTION 2. BACKGROUND

This section is designed to provide background information on CHIP program(s) funded through Title XXI.

2.1 How are Title XXI funds being used in your State?

2.1.1 List all programs in your State that are funded through Title XXI. (Check all that apply.)

___ Providing expanded eligibility under the State's Medicaid plan (Medicaid CHIP expansion)

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

_X_ Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (State-designed CHIP program)

Name of program: _NC Health Choice for Children

Date enrollment began (i.e., when children first became eligible to receive services): _October 1, 1998

___ Other - Family Coverage

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other - Employer-sponsored Insurance Coverage

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other - Wraparound Benefit Package

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other (specify) _____

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

2.1.2 **If State offers family coverage:** Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs. **N/A**

2.1.3 **If State has a buy-in program for employer-sponsored insurance:** Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs**. N/A**

2.2 What environmental factors in your State affect your CHIP program? (Section 2108(b)(1)(E))

2.2.1 How did pre-existing programs (including Medicaid) affect the design of your CHIP program(s)?

The NC Health Choice for Children program was designed by the North Carolina General Assembly from elements from the dependent coverage of the North Carolina Teachers and State Employees Comprehensive Major Medical Plan and Medicaid. In the compromise worked out by the General Assembly and by Governor Hunt, the decision was made that special needs children had to be covered to the Medicaid standard and that dental, vision and hearing had to be added to the State Employees Health Plan dependent coverage package to make the benefit equivalent to Medicaid.

One factor in the design of North Carolina's program is that North Carolina's Teachers' and State Employees' Comprehensive Major Medical Plan is offered to state employees so they can purchase at full cost a health insurance program for their children, but no state or other public funds underwrite that program, therefore state employees' and teachers' children in North Carolina who met the uninsurance criteria (six months uninsured for the first six months of the program, two months uninsured after April 1, 1998) are eligible for NC Health Choice for Children.

2.2.2 Were any of the preexisting programs "State-only" and if so what has happened to that

program?

__X_ **No pre-existing programs were "State-only" There did exist a Caring Program for Children which was operated through private donations and a very limited state appropriation. It was managed by a board and went out of business on September 30, 1998. At its peak, it served 8,000 children. All of these children were permitted to enter the NC Health Choice for Children program with no waiting period.**

___ One or more pre-existing programs were "State only" !Describe current status of program(s): Is it still enrolling children? What is its target group? Was it folded into CHIP?

2.2.3 Describe changes and trends in the State since implementation of your Title XXI program that "affect the provision of accessible, affordable, quality health insurance and healthcare for children." (Section 2108(b)(1)(E))

Examples are listed below. Check all that apply and provide descriptive narrative if applicable. Please indicate source of information (e.g., news account, evaluation study) and, where available, provide quantitative measures about the effects on your CHIP program.

__X_ Changes to the Medicaid program

___ Presumptive eligibility for children
___ Coverage of Supplemental Security Income (SSI) children
__X_ Provision of continuous coverage (specify number of months __12_)
___ Elimination of assets tests
_X__ Elimination of face-to-face eligibility interviews (permitted, not required for children)
___ Easing of documentation requirements

_X__ Impact of welfare reform on Medicaid enrollment and changes to AFDC/TANF (specify) **We originally saw the reduction of some 28,000 Medicaid children as a result of losing TANF coverage. The NC Division of Medical Assistance is making targeted efforts to reenroll these children through direct mail and other mechanisms for finding them.**

X_ Changes in the private insurance market that could affect affordability of or accessibility to private health insurance

___ Health insurance premium rate increases
___ Legal or regulatory changes related to insurance
___ Changes in insurance carrier participation (e.g., new carriers entering market or existing carriers exiting market)
___ Changes in employee cost-sharing for insurance
___ Availability of subsidies for adult coverage

_X Other (specify) _) **Our estimates show that the percent of children with incomes between 201-300% of the federal poverty level who have insurance has decreased from 84.2% in 1997 to 82.7% in 1999, suggesting that there are some changes occurring in the private market that are negatively affecting affordability. (Evaluation by Cecil G. Sheps Center for Health Services Research (UNC-CH)**

___ Changes in the delivery system

___ Changes in extent of managed care penetration (e.g., changes in HMO, IPA, PPO activity)

___ Changes in hospital marketplace (e.g., closure, conversion, merger)

___ Other (specify) _**According to the NC Department of Insurance and the Cecil Sheps Center for Health Statistics there have been no substantive changes in the delivery system. HMO rates were increased by a very large percentage, but not outside the national norm in terms of actual dollars**.

___ Development of new health care programs or services for targeted low-income children (specify) None known.

__X Changes in the demographic or socioeconomic context

_X Changes in population characteristics, such as racial/ethnic mix or immigrant status (specify) _**We are hearing reports from all over North Carolina that our Hispanic population is growing exponentially. We are hearing that numbers of elementary schools are now more than 50 percent Hispanic in eastern and central North Carolina. There is no CPS data to support these observations. CPS data would indicate that Hispanics comprise about 2 percent of the overall population. We currently have a 5% Hispanic participation in our program. We do not have a measure to tell us if we are adequately penetrating this market.**

___ Changes in economic circumstances, such as unemployment rate (specify) none known.

_X__ Other (specify) **The overall population of North Carolina has been growing.. According to estimates from the Office of State Planning North Carolina has had a 3 percent growth of children under the age of 19 from 1997 to 1999**.

___ Other (specify) _____

SECTION 3. PROGRAM DESIGN

This section is designed to provide a description of the elements of your State Plan, including eligibility, benefits, delivery system, cost-sharing, outreach, coordination with other programs, and anti-crowd-out provisions.

3.1 Who is eligible?

3.1.1 Describe the standards used to determine eligibility of targeted low-income children for child health assistance under the plan. For each standard, describe the criteria used to apply the standard. If not applicable, enter "NA."

Table 3.1.1

	Medicaid CHIP Expansion Program	**State-designed CHIP Program**	**Other CHIP Program*** _____ _____ __
Geographic area served by the plan (Section 2108(b)(1)(B)(iv))		**The state of North Carolina**	
Age		**0-18**	
Income (define countable income)		**Up to 200% of the federal poverty level. Countable income consists of gross earnings minus allowable deductions and disregards of income as well as sources of unearned income. Allowable deductions include $90 (monthly) for business deductions, $175 (over age 2) or $200 (under age 2) (monthly) for child care costs (by child). County can deduct amounts paid for court ordered child support to children not living in the home. Other sources of unearned income include Veteran's Benefits, Retirement benefits, unemployment insurance, worker's compensation, dividends and interest from stocks and bonds, etc.**	
Resources (including any standards relating to spend downs and disposition of resources)		**N/A**	

Residency requirements		**Resident of State of NC**	
Disability status		**N/A**	
Access to or coverage under other health coverage (Section 2108(b)(1)(B)(i))		**First six months of the program—a six-month waiting period; After April 1, 1999 a two month waiting period**	
Other standards (identify and describe)		**Must be a citizen or qualified alien; not incarcerated, not in a long term care facility or psychiatric hospital/institution, uninsured (six months from October 1, 1998 to March 30, 1999; two months from April 1, 1999 forward), state resident, under age 19, and ineligible for Medicaid.**	

**Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".*

3.1.2 How often is eligibility redetermined?

Table 3.1.2			
Redetermination	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
Monthly			
Every six months			
Every twelve months		**X**	
Other (specify)			

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.1.3 Is eligibility guaranteed for a specified period of time regardless of income changes? (Section 2108(b)(1)(B)(v))

__**X**_ Yes ≡ Which program(s)? __**NC Health Choice for Children**

For how long?_____**12 months**

___ No

3.1.4 Does the CHIP program provide retroactive eligibility?

_ Yes ≡ Which program(s)?

How many months look-back?

_**X**__ No

3.1.5 Does the CHIP program have presumptive eligibility?

___ Yes ≡ Which program(s)?

Which populations?

Who determines?

__**X**_ No

3.1.6 Do your Medicaid program and CHIP program have a joint application?

__**X**_ Yes ≡ Is the joint application used to determine eligibility for other State programs? **NO** If yes, specify.

___ No

3.1.7 Evaluate the strengths and weaknesses of your *eligibility determination* process in increasing creditable health coverage among targeted low-income children

***Strengths of eligibility process*: one eligibility worker examines the application and determines if the child is eligible for Medicaid or S-CHIP in one eligibility review, this shortens the time involved and the potential for error. Shorter & simpler form that can be mailed in or submitted to health department or social services office provides more options for citizens and ease of access. Publication of the application in Spanish has assisted Hispanic citizens in accessing the system. Toll free number to access the form has made the process simpler.**

***Weaknesses of eligibility determination process*: Requirements of the self-employed that they must submit a year's worth of business records has proven cumbersome and has apparently caused some potential applicants to fail to complete their forms. The requirement of a $50/$100 enrollment fee is the leading cause of denied applications. Counties also report that attempts to collect the fee (and the one-month's worth of pay stubs) slow the process and cost more in time than the money collected. There is also a need to retool the thinking of eligibility workers into a form of insurance agent. The requirement of a two-month waiting period with no insurance has reportedly presented a hardship on families of special needs children who may be severely underinsured and in need of an adequate, affordable health insurance program. Each of these concerns is now under examination.**

3.1.8 Evaluate the strengths and weaknesses of your *eligibility redetermination* process in increasing creditable health coverage among targeted low-income children. How does the redetermination process differ from the initial eligibility determination process?

Strengths: **There are few differences in redetermination and determination. The same form is used and is mailed to the family during the process. The family is asked to fill out the form, sign it and return it with any appropriate paperwork. A strength of the re-enrollment process is the automated notification of need to reenroll. The Eligibility Information System recognizes end of enrollment period and automatically sends re-enrollment form to family. Only the last month of the reporting year was involved in redetermination. We are still in the process of assessing weaknesses in the systems and corrections/adjustments that may need to be made.**

3.2 What benefits do children receive and how is the delivery system structured? (Section 2108(b)(1)(B)(vi))

3.2.1 Benefits

Please complete Table 3.2.1 for each of your CHIP programs, showing which benefits are covered, the extent of cost sharing (if any), and benefit limits (if any).

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose "select" "table." Once the table is highlighted, copy it by selecting "copy" in the Edit menu and then "paste" it under the first table.

Table 3.2.1 CHIP Program Type _____

Benefit	Is Service Covered? (* = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Inpatient hospital services	*		
Emergency hospital services	*	**$20.00 copay for children in the 151% FPL and greater**	
Outpatient hospital services	*		
Physician services	*	**$5.00 copay for children in the 151% FPL and greater**	
Clinic services	*		
Prescription drugs	*	**$6.00 copay for children in the 151% FPL and greater**	
Over-the-counter medications			
Outpatient laboratory and radiology services	*		
Prenatal care			
Family planning services	*		

Inpatient mental health services	*		**Needs prior approval from Mental Health Case Manager before being admitted**
Outpatient mental health services	*		**Up to 26 visits covered in Plan year without getting prior approval. Over 26 visits covered if approved in advance by the Mental Health Case Manager**
Inpatient substance abuse treatment services	*		**Needs prior approval from Mental Health Case Manager before being admitted**
Residential substance abuse treatment services	*		**Needs prior approval from Mental Health Case Manager before being admitted**
Outpatient substance abuse treatment services	*		**Up to 26 visits covered in plan year without getting prior approval. Over 26 visits covered if approved in advance by the Mental Health Case Manager**
Durable medical equipment	*		**Must be medically necessary. Need prior approval for all purchases over $250**
Disposable medical supplies	*		
Preventive dental services	*		**Covered for cleaning and scaling, filings, sealants and flouride treatments (once every 6 months)**
Restorative dental services	*		**Covered for simple tooth pulling (pulling impacted teeth are not covered), removal of part of the nerve (pulpotomy, and stainless steel crowns)**
Hearing screening	*		
Hearing aids	*		**Prior approval necessary**
Vision screening	*		
Corrective lenses (including eyeglasses)	*		**Prior approval needed. Benefits limited to one set of glasses (lenses) or contacts once every 12 months. Frames are limited to one set every 24 months.**

Developmental assessment			
Immunizations	*		
Well-baby visits	*		**Unlimited well-baby visits up to 1 year of age**
Well-child visits	*		**Limited to:** **3 visits each year between 1 and 2 years of age;** **1 visit each year between 2 and 7 years of age;** **1 visit every 3 years between 7 and 19 years of age**
Physical therapy	*		**Prior approval required when rendered in the home**
Speech therapy	*		**Prior approval required when given in home or office**
Occupational therapy	*		**Prior approval required when given in the home.**
Physical rehabilitation services	*		
Podiatric services	*		
Chiropractic services	*		**Limited to $2,000 each year**
Medical transportation	*		**Must be medically necessary and prior approval is required for land or air trips over 50 miles**
Home health services	*		**Limited to private duty nursing, skilled nursing visits and services of home care aides under the direct supervision of a registered nurse (RN). Prior approval required for all home health services.**
Nursing facility	*		**Skilled nursing facility care (short-term skilled care to medically stabilize the child). Prior approval is required.**
ICF/MR	*		**Covered with prior approval.**
Hospice care	*		**Covered with prior approval.**
Private duty nursing	*		**Covered with prior approval**
Personal care services			
Habilitative services			

Case management/Care coordination	*		**Only available for children with special needs. Prior approval necessary.**
Non-emergency transportation			
Interpreter services			
Other (Specify) **Emergency Respite Care**	*		**Only available for families of children with special needs. Prior approval necessary.**
Other (Specify)			
Other (Specify)			

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose "select" "table." Once the table is highlighted, copy it by selecting "copy" in the Edit menu and then "paste" it under the first table.

Note from North Carolina regarding the benefit structure. The scope, depth and breadth of the State Employees Plan was greater than expected. The addition of vision, dental and hearing were initial challenges that were successfully met. The key in communicating the benefits and in receiving suggested changes in the benefits structure was a provider advisory group comprised of the majority of health disciplines most likely to interact with children.

3.2.2 Scope and Range of Health Benefits (Section 2108(b)(1)(B)(ii))

Please comment on the scope and range of health coverage provided, including the types of benefits provided and cost-sharing requirements. Please highlight the level of preventive services offered and services available to children with special health care needs. Also, describe any enabling services offered to CHIP enrollees. (Enabling services include non-emergency transportation, interpretation, individual needs assessment, home visits, community outreach, translation of written materials, and other services designed to facilitate access to care.)

North Carolina Health Choice for Children offers a broad range of benefits. The benefits are the same as those offered to teachers and state workers plus vision, dental and hearing and special needs coverage up to the Medicaid level. There is no cost sharing below 150% of the federal poverty level and only limited cost sharing above 150% of poverty. Cost sharing consists of an enrollment fee of $50 for one child or $100 for two or more children and co-payments of $5 for non-preventive visits to a physician or a clinic, $6 per prescription drug and $20 for non-emergency, emergency room use.

Preventive services are recommended to follow the American Academy of Pediatrics recommendations and are provided without copay accordingly.

The concept under which the special health care needs component of the NC Health Choice for Children Program was developed was to assure that no child would be "labeled" as special needs. Rather that every child with an initially denied claim would have that claim internally referred for consideration under the special needs provision without the provider or parent knowing of this referral. If the child's claim met special needs critiera, it would be paid. The practice of the program has been that the core plan is rich enough that only limited referrals to the special needs fund has been necessary.

Children with special health care needs are eligible to receive all services in the core plan and an additional set of wraparound services that makes the NC Health Choice for Children benefit package equal to the benefit package under the state Medicaid program. Additional services, equipment and supplies that may be covered for children with special needs through Health Choice include:

- **Nutrition therapy**
- **Formulas for children fed by tube**
- **Aids for daily living and personal care**
- **Seating and positioning equipment**
- **Standing and walking aids**
- **Accessibility equipment**
- **Wheeled mobility accessories**
- **Miscellaneous supplies (diabetes supplies, enema kits, underpads/diapers, nebulizer kids)**
- **Augmentative communications devices**

For children with mental health, developmental disabilities, and substance abuse problems, services may include:

- **Day treatment**
- **High risk intervention**
- **Client behavioral intervention**
- **Case management**

The state child health insurance legislation also authorizes the provision of emergency respite care and service coordination to children with special health care needs. Both of these services have been under development during the first year of the program operation.

3.2.3 Delivery System

Identify in Table 3.2.3 the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Check all that apply.

Table 3.2.3			
Type of delivery system	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
A. Comprehensive risk managed care organizations (MCOs)			
Statewide?	___ Yes ___ No	___ Yes **X** No	___ Yes ___ No
Mandatory enrollment?	___ Yes ___ No	___ Yes **X** No	___ Yes ___ No
Number of MCOs		**0**	
B. Primary care case management (PCCM) program		**N/A**	
C. Non-comprehensive risk contractors for selected services such as mental health, dental, or vision (specify services that are carved out to managed care, if applicable)		**N/A**	
D. Indemnity/fee-for-service (specify services that are carved out to FFS, if applicable)		**Statewide**	
E. Other (specify) **Value Options, a subcontractor of Blue Cross, Blue Shield of North Carolina case manages the program's mental health benefit but is not at risk.**		**Statewide**	
F. Other (specify)			
G. Other (specify)			

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.3 How much does CHIP cost families?

3.3.1 Is cost sharing imposed on any of the families covered under the plan? (Cost sharing includes premiums, enrollment fees, deductibles, coinsurance/ copayments, or other out-of-pocket expenses paid by the family.)

___ No, skip to section 3.4

__**X**_ Yes, check all that apply in Table 3.3.1

Table 3.3.1

Type of cost-sharing	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program*_____ _____ _
Premiums			
Enrollment fee		**Yes, for those above 150% fpl=$50 for one child; $100 for two or more children once a year at the time of enrollment**	
Deductibles			
Coinsurance/copayments**		**Yes -- $5 for non preventive physician's visit, $6 for prescription drug, $20 for non emergency emergency room**	
Other (specify) _____			

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

**See Table 3.2.1 for detailed information.

3.3.2 **If premiums are charged:** What is the level of premiums and how do they vary by program, income, family size, or other criteria? (Describe criteria and attach schedule.) How often are premiums collected? What do you do if families fail to pay the premium? Is there a waiting period (lock-out) before a family can re-enroll? Do you have any innovative approaches to premium collection?

3.3.3 **If premiums are charged:** Who may pay for the premium? Check all that apply. (Section 2108(b)(1)(B)(iii))

___ Employer
___ Family
___ Absent parent
___ Private donations/sponsorship
___ Other (specify) _____

3.3.4 **If enrollment fee is charged:** What is the amount of the enrollment fee and how does it vary by program, income, family size, or other criteria? **For those above $150% of the federal poverty level, there is an enrollment fee of $50 for a child, up to $100 for two or more children. It is collected at the time of enrollment as part of the enrollment process.**

3.3.5 **If deductibles are charged:** What is the amount of deductibles (specify, including variations by program, health plan, type of service, and other criteria)?

3.3.6 How are families notified of their cost-sharing requirements under CHIP, including the 5 percent cap? **The information is provided at the time of enrollment through the NC Health Choice Benefits Booklet. Cost sharing is printed on the NC Health Choice Card. At the time of approval for CHIP coverage a letter is mailed to the family notifying them of their cost-sharing requirements.When a family has reached its 5% cap a letter is generated from Blue Cross/Blue Shield informing them of this fact and asking them to present the letter to their providers so they will not have to pay copayments. No family has yet to reach the 5% limit.**

3.3.7 How is your CHIP program monitoring that annual aggregate cost-sharing does not exceed 5 percent of family income? Check all that apply below and include a narrative providing further details on the approach.

___ Shoebox method (families save records documenting cumulative level of cost sharing)
__**X**_ Health plan administration **(**Health plans track cumulative level of cost sharing)

The claims processing system accumulates the copay amounts taken on each claim. When a claim is processed that meets the 5 percent cap, a report is automatically generated. All the children's policies are marked for the remainder of the benefit period so that future claims do not take any additional copays. A letter is generated and sent to the family notifying them

that they have reached their copay cap and to use the letter as proof when receiving future services.

___ Audit and reconciliation (State performs audit of utilization and cost sharing)
___ Other (specify)_____

3.3.8 What percent of families hit the 5 percent cap since your CHIP program was implemented? (If more than one CHIP program with cost sharing, specify for each program.)

Since the S-CHIP program was implemented there have not been any families that have met the cost-sharing cap.

3.3.9 Has your State undertaken any assessment of the effects of premiums on participation or the effects of cost sharing on utilization, and if so, what have you found?

We do not have premiums; however, we do have an annual enrollment fee of $50 for one child and $100 for two or more children for those families above 150% of the federal poverty level. We have found that the leading cause for denial of applications (all income levels) is for failure to pay the enrollment fee. There were slightly over 4,000 children who were denied during the first year of the program for failure to pay enrollment fees.

3.4 How do you reach and inform potential enrollees?

3.4.1 What client education and outreach approaches does your CHIP program use?

Please complete Table 3.4.1. Identify all of the client education and outreach approaches used by your CHIP program(s). Specify which approaches are used (T=yes) and then rate the effectiveness of each approach on a scale of 1 to 5, where 1=least effective and 5=most effective.

Table 3.4.1						
Approach	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program* _____	
	T = Yes	Rating (1-5)	T = Yes	Rating (1-5)	T = Yes	Rating (1-5)
Billboards			T	2		
Brochures/flyers			T	4		
Direct mail by State/enrollment broker/administrative contractor			T	3		
Education sessions			T	4		
Home visits by State/enrollment broker/administrative contractor			T	5		
Hotline			T	4		
Incentives for education/outreach staff			No			
Incentives for enrollees			T	3		
Incentives for insurance agents			T	2		
Non-traditional hours for application intake			T	3		
Prime-time TV advertisements			T	3		
Public access cable TV			T	2		
Public transportation ads			No			
Radio/newspaper/TV advertisement and PSAs			T	3		
Signs/posters			T	3		
State/broker initiated phone calls			T	4		
Other (specify) local grassroots outreach coalitions*			T	5		
Other (specify) outreach workers (health check coordinators			T	5		

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

Under the leadership of our statewide outreach committee, North Carolina chose to use a local grassroots outreach approach with SCHIP. Each of our 100 counties was asked to form an outreach coalition led by county social services and public health directors to pull in a diverse group of individuals representing public and private NFP agencies, churches, businesses, schools/day cares, health care providers, media, consumers, etc.

Local coalitions were asked to consider inclusion of representatives from the following groups in forming their outreach coalition…

- **Health Departments**
- **Department of Social Services**
- **Community/Rural/Migrant Health Centers**
- **Private Practice Provider(s)**
- **Hospital**
- **Mental Health Center**
- **Schools**
- **Child Care (Includes Smart Start Partnership/Child Care Resource and Referral/ and/or Head Start Program).**
- **Family Support Network**
- **Business and Industry**
- **Chamber of Commerce**
- **Media**
- **Churches**
- **Housing Authority**
- **Other Private Not-For-Profit Community Organizations**
- **Consumers**

They were also asked to assure that the coalition was ethnically diverse.

3.4.2 Where does your CHIP program conduct client education and outreach?

Please complete Table 3.4.2. Identify all the settings used by your CHIP program(s) for client education and outreach. Specify which settings are used (T=yes) and then rate the effectiveness of each setting on a scale of 1 to 5, where 1=least effective and 5=most effective.

Table 3.4.2						
Setting	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program* _____	
	T = Yes	Rating (1-5)	T = Yes	Rating (1-5)	T = Yes	Rating (1-5)
Battered women shelters			T	2		
Community sponsored events			T	4		
Beneficiary's home			T	5		
Day care centers			T	5		
Faith communities			T	3		
Fast food restaurants			T	2		
Grocery stores			T	2		
Homeless shelters			T	2		
Job training centers			T	1		
Laundromats			T	2		
Libraries			T	3		
Local/community health centers			T	4		
Point of service/provider locations			T	4		
Public meetings/health fairs			T	3		
Public housing			T	3		
Refugee resettlement programs						
Schools/adult education sites			T	5		
Senior centers						
Social service agency			T	5		
Workplace			T	3		
Other (specify) Division of Motor Vehicles Offices			T	3		
Other (specify) Not for Profit Community Agencies such as the YMCA/YWCA, United Way, etc.			T	4		

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.4.3 Describe methods and indicators used to assess outreach effectiveness, such as the number of children enrolled relative to the particular target population. Please be as specific and detailed as possible. Attach reports or other documentation where available.

- **Mailed monthly updates to local coalitions, including enrollment data, so they could evaluate the success of their efforts in relation to other counties and the state.**
- **The Cecil G. Sheps Center for Health Services Research/UNC-CH did a consumer survey of 1,796 newly enrolled children during 6/99-7/99. With 1,346 returned surveys, they achieved an 74% response rate. The results are just now becoming available. The response to the question, "How did you learn about NC Health Choice?" is helpful to our outreach evaluation.**
- **Within the first 2-4 months of program implementation, we conducted a coalition survey.**
- **The NC Family Health Resource Line, which is the State's Title V/MCH Hotline, was utilized for information, referral and advocacy in relation to our SCHIP Program. Reports from the resource line provide data on total call volume, age and race/ethnicity of callers, and how individuals learned about the line.**
- **Anecdotal information from local coalition staff about strategies tried and which are most effective**

3.4.4 What communication approaches are being used to reach families of varying ethnic backgrounds?

Through our Duke Endowment Health Choice Minority Outreach Grant, we are targeting outreach to African American, Hispanic Latino, and Native American Communities. What we are learning from those projects is that outreach is most successfully accomplished when the message is delivered personally from someone they trust. The different projects have utilized door to door canvassing, home visiting, and outreach to community agencies, organizations, health care providers, businesses, media, and churches that specifically serve the population being targeted.

3.4.5 Have any of the outreach activities been more successful in reaching certain populations? Which methods best reached which populations? How have you measured their effectiveness? Please present quantitative findings where available.

In general, it is our belief that North Carolina has done well with SCHIP outreach because the major thrust was a local grassroots outreach coalition strategy. Each of the 100 counties was asked to form a local outreach coalition with diverse representation (see 3.4.1). That strategy assured that our outreach would be more personal and tailored to the local community. The state's role then became one of supporting the local coalitions' efforts by providing the tools… print materials, electronic media, monthly programmatic and data updates, consultation/technical assistance, workshops, outreach to state and regional organizations, newspaper coverage, newsletter articles, etc. The most effective outreach strategies to the general population, based on consumer and coalition surveys, have been outreach through schools, child care providers, and public agencies (local departments of social services and

health especially).
We have been particularly successful in our outreach to families at lower income levels. Our SCHIP Program is free for families < 150% FPL, but adds enrollment fees ($50/child up to maximum of $100/family) for families >150% FPL Of the children enrolled, 70% are in families below 150% FPL; 30% are above. Our failure to capture a higher number at the upper income levels has been attributed to two causes:

- **The enrollment fee is a barrier and continues to be the most common reason for a denied application (30%). This does not include families who choose not to apply due to the enrollment fee.**
- **Initially we targeted outreach efforts to families most likely to be eligible. Thus, we focused on children in subsidized child care; children eligible for WIC, free and reduced price school lunch, and other subsidized nutrition programs; children previously eligible for Medicaid; children previously eligible for the Caring Program for Children; families applying for public housing; etc. While this targeting in the midst of a general outreach campaign was appropriate for year one, we are now redirecting efforts to enroll families in higher income levels by doing more *personal* outreach through schools, business and industry, the provider community, and the faith community.**

With regard to targeting outreach to minority populations, we feel that it is most successfully accomplished when it is:
- **Personal**
- **From someone they trust, preferably of their race.**
- **From their media.**
- **From their own community organizations, churches, businesses, etc.**
- **Utilizing materials developed with sensitivity to their culture.**

Our success in recruiting minority populations is reflected in enrollment data by race and through hotline data (although we only recently began collecting demographics on ethnicity).

The race distribution of enrolled children:
54% Caucasian; 35% African-American; 5% Hispanic/Latino; 2% Native American; 1% Asian; 3% Other.

The race distribution for the state's population:
73% Caucasian; 22% African-American; 2% Hispanic/Latino; 1% Native American. (State Center)

3.5 What other health programs are available to CHIP eligibles and how do you coordinate with them? (Section 2108(b)(1)(D))

Describe procedures to coordinate among CHIP programs, other health care programs, and non-health care programs. Table 3.5 identifies possible areas of coordination between CHIP and other programs (such as Medicaid, MCH, WIC, School Lunch). Check all areas in which coordination takes place and specify the nature of coordination in narrative text, either on the

table or in an attachment.

Table 3.5				
Type of coordination	Medicaid*	Maternal and child health	Other (specify) Teachers and State Employees Comprehensive Major Medical Plan	Other (specify) _____
Administration	*			
Outreach		*		
Eligibility determination	*			
Service delivery			*	
Procurement	*	*	*	
Contracting	*	*	*	
Data collection	*		*	
Quality assurance	The N.C. Division of Medical Assistance has incorporated Health Choice into the assessment of patient satisfaction for Medicaid Managed Care enrollees. The Division is contracting with the University of North Carolina at Charlotte to perform the NCQA Consumer Assessment of Health Plan Survey (CAPHS) and analyze the results with comparisons across all Medicaid managed care programs and health Choice (see 4.5.1) Once the data is accessible within the Division , DMA also plans to produce utilization data that corresponds to Medicaid managed care utilization data.			
Other (specify) **Special Needs**		*		
Other (specify)				

*Note: This column is not applicable for States with a Medicaid CHIP expansion program only.

**** The Management structure of North Carolina Health Choice for Children is built intrinsically on coordination among existing agencies. Benefits are managed through the NC Teachers and State Employees Comprehensive Major Medical Plan County Medicaid offices and public health agencies establish eligibility. The Division of Medical Assistance is responsible for eligibility policy, quality oversight, funds management linkages to the federal government. The Division of Public Health's Title V program is responsible for outreach and special needs services. Two separate private companies and one public agency deal with different aspects of information management. Eligibility information is handled through the Division of Information Management and EDS federal. Claims information is handled through Blue Cross Blue Shield, claims processing agent for the State Employees Health Plan. Ongoing cooperative, coordinated efforts among all of these entities have been essential to the successful operation of this program. Telephone, email and at least weekly meetings have been the mechanisms used for program management.**

3.6 How do you avoid crowd-out of private insurance?

3.6.1 Describe anti-crowd-out policies implemented by your CHIP program. If there are differences across programs, please describe for each program separately. Check all that apply and describe.

X Eligibility determination process:

_X_ Waiting period without health insurance (specify) **Six months waiting period from October 1, 1998 to April 1, 1999. After April 1, 1999 two months waiting period**
___ Information on current or previous health insurance gathered on application (specify)
___ Information verified with employer (specify)
___ Records match (specify)
X Other (specify) **Survey of new enrollees regarding previous insurance**
X Other (specify) **Reports of violators by insurance companies (BCBS), social workers, or providers or others are turned over to the fraud and abuse section of the NC Division of Medical Assistance**

___ Benefit package design:

___ Benefit limits (specify)
X Cost-sharing (specify) **Above 150% fpl $50 enrollment fee for one child; $100 for two or more children**
___ Other (specify)
___ Other (specify)

Other policies intended to avoid crowd out (e.g., insurance reform):

___ Other (specify)
___ Other (specify) _____

3.6.2 How do you monitor crowd-out? What have you found? Please attach any available reports or other documentation.

Crowd out is difficult to monitor because assessment depends on self-reported information on prior insurance and the reliability of these data is not clear. For the 38.5% of all NCHC enrollees who came straight from Medicaid coverage, crowdout is not an issue. Using data from a survey of a sample of NCHC enrollees conducted by the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill, very rough estimates of the percent of NCHC enrollees whose parents intentionally dropped other health insurance coverage in order for their child to qualify for NCHC can be made. Specifically, one question in the sample survey asks why the child's most recent insurance coverage ended. One possible response to this question was that the "child could not have other insurance and still qualify for NCHC". Using the survey sample response to that question and applying it to the total NCHC enrollee population, it would appear that the parents of 0.7% of all enrollees may have intentionally dropped coverage so their child could qualify. It should be noted that the data do not allow for control of multiple NCHC enrollees in one family; it is assumed that each child's coverage decision is made independently.

Because of the tendency of survey respondents to under-report sensitive information, the estimate of 0.7% crowd-out represents a lower bound of the true range. The survey also asked respondents whether they had dropped their child's insurance because it was too expensive or it did not pay for enough services. Aggregating affirmative responses to these two questions with the question regarding intentional discontinuation of coverage gives an estimate of an upper bound for the rate of crowd-out. Considering children whose parent (a) cited at least one of the three reasons for dropping health insurance and (b) dropped their prior coverage within six months or less of the time they enrolled in NCHC to meet State requirements, to be those whose insurance was arguably "crowded-out", results in a less stringently defined "crowd-out" rate. Applying this new crowd-out rate to all NCHC enrollees gives an upper bound for the crowd out rate of 8.3% (source: Rebecca T. Slifkin, Ph.D.
Director, Program on Health Care Economics and Finance
Cecil G. Sheps Center for Health Services Research
CB #7590, 725 Airport Road
Chapel Hill, N.C. 27599-7590

Section 4. Program Assessment

This section is designed to assess the effectiveness of your CHIP program(s), including enrollment, disenrollment, expenditures, access to care, and quality of care.

4.1 Who enrolled in your CHIP program?

4.1.1 What are the characteristics of children enrolled in your CHIP program? (Section 2108(b)(1)(B)(i))

Please complete Table 4.1.1 for each of your CHIP programs, based on data from your HCFA quarterly enrollment reports. Summarize the number of children enrolled and their characteristics. Also, discuss average length of enrollment (number of months) and how this varies by characteristics of children and families, as well as across programs.

States are also encouraged to provide additional tables on enrollment by other characteristics, including gender, race, ethnicity, parental employment status, parental marital status, urban/rural location, and immigrant status. Use the same format as Table 4.1.1, if possible.

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose "select" "table." Once the table is highlighted, copy it by selecting "copy" in the Edit menu and then "paste" it under the first table.

Source: North Carolina has used its most current month-end (2/29/2000) MMIS Eligibility Master to prepare both the requested Table 4.1.1 and all the supplemental tables in order that data on all tables will crossfoot. Enrollees in North Carolina's State Only Program, North Carolina Health Choice for Children (NCHC), are carried on the State MMIS Eligibility master in the same record format as any other Title XIX eligible. As of 2/29/2000 all case actions related to FFY99 NCHC, but possibly delayed in those counties most severely affected by Hurricane Floyd flooding would have processed. An Enrollee is defined as any individual who had at least one day of NCHC benefit coverage during FFY99. An enrollee who disenrolled, but was re-enrolled as of the last month of FFY99 is not counted as a Disenrollee for FFY99. This is consistent with the definition used for disenrollment in a quarter. The urban/rural county distinctions are based on the US Census' 1996 metro designations from their 1998 Area Resource File. (http://www.census.gov/population/estimates/metro-city/maupdate.txt)

Table 4.1.1 CHIP Program Type: State Only Program ***North Carolina Health Choice for Children (NCHC)*** ***Age and Income Crosstab***						
Characteristics	Number of children ever enrolled		Average number of months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
All Children	N/A	59,542	N/A	6.94	N/A	2,695
Age						
Under 1		106		5.81		9
1-5		13,829		6.61		433
6-12		31,075		7.08		1,151
13-18		14,532		6.97		1,102
Countable Income Level						
At or below 150% FPL		41,679		6.79		2,223
Above 150% FPL		17,863		7.28		472
Age and Income						
Under 1						
At or below 150% FPL		11		4.54		5
Above 150% FPL		95		5.95		4
1-5						
At or below 150% FPL		6,662		6.40		278
Above 150% FPL		7,167		6.80		155
6-12						
At or below 150% FPL		23,841		6.90		1,013
Above 150% FPL		7,234		7.64		138

13-18							
	At or below 150% FPL		11,165		6.78		927
	Above 150% FPL		3,367		7.58		175
Type of plan							
Fee-for-service			59,542		6.94		2,695
Managed care							
PCCM							

The following are additional tables on enrollment by gender, ethnicity, age, income and urban/rural location as carried on our MMIS Eligibility Master. An alpha suffix has been added to identify each table as indicated in the following list:

Table 4.1.1.a Age and Gender Crosstab
Table 4.1.1.b Age and Ethnicity Crosstab
Table 4.1.1.c Age, Ethnicity, and Income Crosstab
Table 4.1.1.d Ethnicity and Income Crosstab
Table 4.1.1.e Age, Gender, and Income Crosstab
Table 4.1.1.f Ethnicity, Gender, Age, and Income Crosstab
(for counties designated as urban in population density)
Table 4.1.1.g Ethnicity, Gender, Age, and Income Crosstab
(for counties designated as rural in population density)

Table 4.1.1.a CHIP Program Type: State Only Program ***North Carolina Health Choice for Children (NCHC)*** ***Age and Gender Crosstab***						
Characteristics	Number of children ever enrolled		Average number of months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
All Children	N/A	59,542	N/A	6.94	N/A	2,695
Age						
Under 1		106		5.81		9
1-5		13,829		6.61		433
6-12		31,075		7.08		1,151
13-18		14,532		6.97		1,102
Gender						
Male		30,039		6.97		1,283
Female		29,503		6.91		1,412
Age and Gender						
Under 1						
Male		57		5.68		4
Female		49		5.95		5
1 – 5						
Male		7,154		6.57		248
Female		6,675		6.65		185
6 – 12						
Male		15,826		7.11		608
Female		15,249		7.03		543
13 – 18						
Male		7,002		7.05		1,283
Female		7,530		6.90		1,412

Type of plan						
Fee-for-service		59,542		6.94		2,695
Managed care						
PCCM						

Table 4.1.1.b CHIP Program Type: State Only Program ***North Carolina Health Choice for Children (NCHC)*** ***Age and Race Crosstab***						
Characteristics	Number of children ever enrolled		Average number of months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
All Children	N/A	59,542	N/A	6.94	N/A	2,695
Age						
Under 1		106		5.81		9
1-5		13,829		6.61		433
6-12		31,075		7.08		1,151
13-18		14,532		6.97		1,102
Ethnicity						
Alaskan Native/ Native America		1,193		6.99		48
Asian/ Pacific Islander		768		6.56		42
Black, Not Hispanic		20,720		6.87		1,109
Hispanic		3,176		6.20		110
Other		1,783		6.83		126
White/ Not Hispanic		31,902		7.07		1,260
Age and Ethnicity						
Under 1						
Alaskan Native/ Native America		2		4.50		1
Asian/ Pacific Islander		0		0.00		0
Black, Not Hispanic		23		5.00		2
Hispanic		14		5.64		2
Other		3		7.0		0
White/ Not Hispanic		64		6.12		4
1 – 5						

Alaskan Native/ Native America		290		6.70		11
Asian/ Pacific Islander		185		5.94		11
Black, Not Hispanic		3,301		6.50		122
Hispanic		1,438		6.02		43
Other		396		6.50		23
White/ Not Hispanic		8,219		6.78		223

Table 4.1.1.b CHIP Program Type: State Only Program ***North Carolina Health Choice for Children (NCHC)*** ***Age and Race Crosstab***						
Characteristics	Number of children ever enrolled		Average number of months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
6 – 12						
Alaskan Native/ Native America		592		7.01		13
Asian/ Pacific Islander		396		6.81		16
Black, Not Hispanic		11,403		6.98		472
Hispanic		1,378		6.32		46
Other		974		6.90		67
White/ Not Hispanic		16,332		7.23		537
13 – 18						
Alaskan Native/ Native America		309		7.32		23
Asian/ Pacific Islander		187		6.64		15
Black, Not Hispanic		5,993		6.87		513
Hispanic		346		6.49		19
Other		410		6.98		36
White/ Not Hispanic		7,287		7.07		496
Type of plan						
Fee-for-service		59,542		6.94		2,695
Managed care						
PCCM						

Table 4.1.1.c CHIP Program Type: State Only Program ***North Carolina Health Choice for Children (NCHC)*** ***Age, Race, and Income Crosstab***						
Characteristics	Number of children ever enrolled		Average number of months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
All Children	N/A	59,542	N/A	6.94	N/A	2,695
Age						
Under 1		106		5.81		9
1-5		13,829		6.61		433
6-12		31,075		7.08		1,151
13-18		14,532		6.97		1,102
Ethnicity						
Alaskan Native/ Native America		1,193		6.99		48
Asian/ Pacific Islander		768		6.56		42
Black, Not Hispanic		20,720		6.87		1,109
Hispanic		3,176		6.20		110
Other		1,783		6.83		126
White/ Not Hispanic		31,902		7.07		1,260
Countable Income Level						
At or below 150% FPL		41,679		6.79		2,223
Above 150% FPL		17,863		7.28		472
Age, Race, and Income						
Under 1						
Alaskan Native/ Native America						
At or below 150% FPL		1		1.00		1
Above 150% FPL		1		8.00		0

Asian/ Pacific Islander							
	At or below 150% FPL		0		0.00		0
	Above 150% FPL		0		0.00		0
Black, Not Hispanic							
	At or below 150% FPL		3		4.00		2
	Above 150% FPL		20		5.15		0

Table 4.1.1.c CHIP Program Type: State Only Program ***North Carolina Health Choice for Children (NCHC)*** ***Age, Race, and Income Crosstab***						
Characteristics	Number of children ever enrolled		Average number of months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Hispanic						
At or below 150% FPL		1		1.00		1
Above 150% FPL		13		6.00		1
Other						
At or below 150% FPL		0		0.00		0
Above 150% FPL		3		7.00		0
White/ Not Hispanic						
At or below 150% FPL		6		6.00		1
Above 150% FPL		58		6.13		3
1 - 5						
Alaskan Native/ Native America						
At or below 150% FPL		156		6.42		7
Above 150% FPL		134		6.81		4
Asian/ Pacific Islander						
At or below 150% FPL		100		6.04		10
Above 150% FPL		85		5.83		1
Black, Not Hispanic						
At or below 150% FPL		1,809		6.35		84
Above 150% FPL		1,492		6.68		38
Hispanic						
At or below 150% FPL		738		6.01		23
Above 150% FPL		700		6.03		20

Other						
At or below 150% FPL		175		6.39		14
Above 150% FPL		221		6.58		9
White/ Not Hispanic						
At or below 150% FPL		3,684		6.51		462
Above 150% FPL		4,535		6.99		75

Table 4.1.1.c CHIP Program Type: State Only Program ***North Carolina Health Choice for Children (NCHC)*** ***Age, Race, and Income Crosstab***						
Characteristics	Number of children ever enrolled		Average number of months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
6 -12						
Alaskan Native/ Native America						
At or below 150% FPL		451		6.90		20
Above 150% FPL		141		7.36		3
Asian/ Pacific Islander						
At or below 150% FPL		313		6.76		14
Above 150% FPL		83		7.00		2
Black, Not Hispanic						
At or below 150% FPL		9,397		6.85		428
Above 150% FPL		2,006		7.58		44
Hispanic						
At or below 150% FPL		1,103		6.24		40
Above 150% FPL		275		6.61		6
Other						
At or below 150% FPL		715		6.56		57
Above 150% FPL		259		7.83		10
White/ Not Hispanic						
At or below 150% FPL		11,862		7.03		462
Above 150% FPL		4,470		7.74		75
13 - 18						
Alaskan Native/ Native America						
At or below 150% FPL		223		7.34		28
Above 150% FPL		86		7.27		5

Asian/ Pacific Islander						
At or below 150% FPL		146		6.82		23
Above 150% FPL		41		6.00		8
Black, Not Hispanic						
At or below 150% FPL		4,928		6.75		451
Above 150% FPL		1,065		7.44		62

Table 4.1.1.c CHIP Program Type: State Only Program ***North Carolina Health Choice for Children (NCHC)*** ***Age, Race, and Income Crosstab***							
Characteristics		Number of children ever enrolled		Average number of months of enrollment		Number of disenrollees	
		FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Hispanic							
	At or below 150% FPL		263		6.41		16
	Above 150% FPL		83		6.72		3
Other							
	At or below 150% FPL		293		6.74		28
	Above 150% FPL		117		7.58		8
White/ Not Hispanic							
	At or below 150% FPL		5,312		6.82		403
	Above 150% FPL		1,975		7.74		93
Type of plan							
Fee-for-service			59,542		6.94		2,695
Managed care							
PCCM							

Table 4.1.1.d CHIP Program Type: State Only Program ***North Carolina Health Choice for Children (NCHC)*** ***Race and Income Crosstab***						
Characteristics	Number of children ever enrolled		Average number of months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
All Children	N/A	59,542	N/A	6.94	N/A	2,695
Ethnicity						
Alaskan Native/ Native America		1,193		6.99		48
Asian/ Pacific Islander		768		6.56		42
Black, Not Hispanic		20,720		6.87		1,109
Hispanic		3,176		6.20		110
Other		1,783		6.83		126
White/ Not Hispanic		31,902		7.07		1,260
Countable Income Level						
At or below 150% FPL		41,679		6.79		2,223
Above 150% FPL		17,863		7.28		472
Ethnicity and Income						
Alaskan Native/ Native America						
At or below 150% FPL		831		6.92		40
Above 150% FPL		362		7.14		8
Asian/ Pacific Islander						
At or below 150% FPL		559		6.64		33
Above 150% FPL		209		6.33		9
Black, Not Hispanic						
At or below 150% FPL		16,137		6.76		965

Above 150% FPL		4,583		7.24		144
Hispanic						
At or below 150% FPL		2,105		6.18		80
Above 150% FPL		1,071		6.23		30

Table 4.1.1 CHIP Program Type: <u>State Only Program</u>
North Carolina Health Choice for Children (NCHC)
Age and Income Crosstab

Characteristics	Number of children ever enrolled		Average number of months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Other						
At or below 150% FPL		1,183		6.58		99
Above 150% FPL		600		7.31		27
White/ Not Hispanic						
At or below 150% FPL		20,864		6.89		1,006
Above 150% FPL		11,038		7.42		254
Type of plan						
Fee-for-service		59,542		6.94		2,695
Managed care						
PCCM						

Table 4.1.1.e CHIP Program Type: State Only Program ***North Carolina Health Choice for Children (NCHC)*** ***Age, Gender, and Income Crosstab***						
Characteristics	Number of children ever enrolled		Average number of months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
All Children	N/A	59,542	N/A	6.94	N/A	2,695
Age						
Under 1		106		5.81		9
1-5		13,829		6.61		433
6-12		31,075		7.08		1,151
13-18		14,532		6.97		1,102
Gender						
Male		30,039		6.97		1,283
Female		29,503		6.91		1,412
Countable Income Level*						
At or below 150% FPL		41,679		6.79		2,223
Above 150% FPL		17,863		7.28		472
Age, Gender, And Income						
Under 1						
Male						
At or below 150% FPL		4		1.5		4
Above 150% FPL		53		6.0		0
Female						
At or below 150% FPL		7		6.28		1
Above 150% FPL		42		5.90		4

1 – 5							
Male							
	At or below 150% FPL		3,424		6.42		156
	Above 150% FPL		3,730		6.71		92
Female							
	At or below 150% FPL		3,238		6.38		122
	Above 150% FPL		3,437		6.90		63

Table 4.1.1.e CHIP Program Type: <u>State Only Program</u>
North Carolina Health Choice for Children (NCHC)
Age, Gender, and Income Crosstab

Characteristics	Number of children ever enrolled		Average number of months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
6 – 12						
Male						
At or below 150% FPL		12,040		6.94		532
Above 150% FPL		3,786		7.66		76
Female						
At or below 150% FPL		11,801		6.86		481
Above 150% FPL		3,448		7.62		62
13 – 18						
Male						
At or below 150% FPL		5,362		6.87		350
Above 150% FPL		1,640		7.62		73
Female						
At or below 150% FPL		5,803		6.70		577
Above 150% FPL		1,727		7.54		102
Type of plan						
Fee-for-service		59,542		6.94		2,695
Managed care						
PCCM						

Table 4.1.1.f CHIP Program Type: State Only Program

North Carolina Health Choice for Children (NCHC)

Ethnicity, Gender, Age, and Income Crosstab (Urban Counties) – Number of Children Ever Enrolled FFY 1999

		Population Density: Urban										
		Countable Income Level										
		At or below 150% FPL					**Above 150% FPL**					**TOTAL**
Ethnicity and Gender		Under 1	1 - 5	6 - 12	13 - 18	Total	Under 1	1 - 5	6 - 12	13 - 18	Total	
Alaskan Native/Native American		0	9	40	18	67	0	8	10	4	22	89
	Male	0	4	20	7	31	0	4	8	3	15	46
	Female	0	5	20	11	36	0	4	2	1	7	43
Asian/Pacific Islander		0	87	250	123	460	0	68	71	35	174	634
	Male	0	40	130	68	238	0	34	35	22	91	329
	Female	0	47	120	55	222	0	34	36	13	83	305
Black, Not Hispanic		2	1,169	5,996	2,945	10,112	15	978	1,293	651	2,937	13,049
	Male	1	577	2,935	1,400	4,913	8	495	665	308	1,476	6,389
	Female	1	592	3,061	1,545	5,199	7	483	628	343	1,461	6,660
Hispanic		1	498	720	186	1,405	13	456	186	54	709	2,114
	Male	1	251	351	96	699	8	227	105	32	372	1,071
	Female	0	247	369	90	706	5	229	81	22	337	1,043
Other		0	103	431	179	713	0	138	162	77	377	1,090
	Male	0	60	232	82	374	0	76	89	34	199	573
	Female	0	43	199	97	339	0	62	73	43	178	517
White/ Not Hispanic		6	1,963	6,326	2,733	11,028	33	2,328	2,369	1,017	5,747	16,775
	Male	1	1,017	3,229	1,341	5,588	18	1,245	1,212	500	2,975	8,563
	Female	5	946	3,097	1,392	5,440	15	1,083	1,157	517	2,772	8,212
All Ethnicities		9	3,829	13,763	6,184	23,785	61	3,976	4,091	1,838	9,966	33,751
	Male	3	1,949	6,897	2,994	11,843	34	2,081	2,114	899	5,128	16,971
	Female	6	1,880	6,866	3,190	11,942	27	1,895	1,977	939	4,838	16,780

Table 4.1.1.g CHIP Program Type: State Only Program
North Carolina Health Choice for Children (NCHC)
Ethnicity, Gender, Age, and Income Crosstab (Rural Counties) – Number of Children Ever Enrolled FFY 1999

		Population Density: Rural										
		Countable Income Level*										
		At or below 150% FPL					**Above 150% FPL**					**TOTAL**
Ethnicity and Gender		Under 1	1 - 5	6 - 12	13 - 18	Total	Under 1	1 - 5	6 - 12	13 - 18	Total	
Alaskan Native/Native American		1	147	411	205	764	1	126	131	82	340	1,104
	Male	0	75	215	100	390	1	78	64	39	182	572
	Female	1	72	196	105	374	0	48	67	43	158	532
Asian/Pacific Islander		0	13	63	23	99	0	17	12	6	35	134
	Male	0	6	35	6	47	0	8	6	3	17	64
	Female	0	7	28	17	52	0	9	6	3	18	70
Black, Not Hispanic		1	640	3,401	1,983	6,025	5	514	713	414	1,646	7,671
	Male	1	313	1,706	930	2,950	3	267	370	195	835	3,785
	Female	0	327	1,695	1,053	3,075	2	247	343	219	811	3,886
Hispanic		0	240	383	77	700	0	244	89	29	362	1,062
	Male	0	126	207	40	373	0	123	51	17	191	564
	Female	0	114	176	37	327	0	121	38	12	171	498
Other		0	72	284	114	470	3	83	97	40	223	693
	Male	0	35	156	53	244	1	46	55	22	124	368
	Female	0	37	128	61	226	2	37	42	18	99	325
White/ Not Hispanic		0	1,721	5,536	2,579	9,836	25	2,207	2,101	958	5,291	15,127
	Male	0	920	2,824	1,239	4,983	14	1,127	1,126	465	2,732	7,715
	Female	0	801	2,712	1,340	4,853	11	1,080	975	493	2,559	6,412
All Ethnicities		2	2,833	10,078	4,981	17,894	34	3,191	3,143	1,529	7,897	25,791
	Male	1	1,475	5,143	2,368	8,987	19	1,649	1,672	741	4,081	13,068
	Female	1	1,358	4,935	2,613	8,907	15	1,542	1,471	788	3,816	12,723

4.1.2 How many CHIP enrollees had access to or coverage by health insurance prior to enrollment in CHIP? Please indicate the source of these data (e.g., application form, survey). (Section 2108(b)(1)(B)(i))

Among all children enrolled in NCHC at some point during the first year of the program (the "ever-enrolled"), data from the Medicaid eligibility files (Division Medical Assistance Decision Support Data Warehouse (DRIVE) & NC Department of Health and Human Resources Eligibility Information System) indicate that 38.48% (22,912 children) came directly from the Medicaid program (defined as having 31 days or less between the last covered day on Medicaid and the first covered day on NCHC). Another 43.59% (25,951 children) had had Medicaid coverage at some point during their lives, but it is not known how many of these children had other forms of insurance between their Medicaid and NCHC coverage. Only 17.93% (10,675 children) of the ever-enrolled were never covered by NC Medicaid, and were thus either uninsured, covered by other types of insurance, or were on Medicaid in another state prior to their enrollment in NCHC.

Analysis of survey data for a sample of NCHC enrollees (survey conducted by Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill) provides further information on insurance coverage prior to NCHC enrollment. Among survey children who did not come directly from Medicaid to NCHC, 45% had at least one parent with health insurance coverage through work. However, the extent to which this coverage represents true access to health insurance for the children is unknown, as data were not collected on whether dependent coverage was available and, if it was, whether the cost of adding dependents was reasonable.

Among the respondents to the survey, 197 (14.6%) reported that the most recent insurance their child had had prior to NCHC was insurance obtained through a parent's work. The majority (71%) of children that had been previously covered through a parent's work lost that coverage because the parent changed or lost their job. Others (8.1%) lost coverage because the parent's employer had dropped the health insurance.

Only 25 respondents to the survey (1.9%) reported that the most recent insurance their child had had prior to NCHC was insurance that the parent had bought on his or her own. Twenty-three of the 25 reported that they dropped this coverage because it was too expensive.

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4.1.3 What is the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children? (Section 2108(b)(1)(C)) **N/A**

4.2Who disenrolled from your CHIP program and why?

Reenrollment began at October 1, 1999 (ffy 2000) and will be dealt with in the ffy2000 report. The disenrollments we have for ffy 1999 are the incidental disenrollments as families move, children age, etc. Those results are shown below.

4.2.1 How many children disenrolled from your CHIP program(s)? **See Table 4.1.1** Please discuss disenrollment rates presented in Table 4.1.1. Was disenrollment higher or lower than expected? **We have no data to compare or to make projections.** How do CHIP disenrollment rates compare to traditional Medicaid disenrollment rates?

4.2.2 How many children did not re-enroll at renewal? How many of the children who did not re-enroll got other coverage when they left CHIP? **Reenrollment began at October 1, 1999 (ffy 2000) and will be dealt with in the ffy2000 report. The disenrollments we have for ffy 1999 are the incidental disenrollments as families move, children age, etc. Those results are shown below.**

4.2.3 What were the reasons for discontinuation of coverage under CHIP? (Please specify data source, methodologies, and reporting period.)

Table 4.2.3

Reason for discontinuation of coverage	Medicaid CHIP Expansion Program		State-designed CHIP Program		Other CHIP Program* _____	
	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total
Total	N/A		2695	100%	N/A	
Access to commercial insurance			387	14.4%		
Eligible for Medicaid			898	33.3%		
Income too high			40	1.5%		
Aged out of program			305	11.3%		
Moved/died			218	8%		
Nonpayment of premium			16	.5%		
Incomplete documentation			114	.4%		
Did not reply/unable to contact			29	1%		
Other (specify) No longer living with caseload			17	.06%		
Other (specify) No longer living with case load as placed in foster care			27	1%		
Other (specifiy) child became SSI			2	.07%		
Other (specifiy) terminated at caseload's request			151	5.6%		
Other (specify) Resident Public distribution			5	.1%		
Other (specify) change in agency policy; client notified			4	.4%		
Don't know			482	17%		

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

4.2.4 What steps is your State taking to ensure that children who disenroll, but are still eligible, re-enroll? Our reenrollment period did not begin until the beginning of FFY 2000. We expect to be able to provide a full analysis at the time of the FFY 2000 report.

4.3 How much did you spend on your CHIP program?

4.3.1 What were the total expenditures for your CHIP program in federal fiscal year (FFY) 1998 and 1999?

FFY 1998 _____**0**_____
FFY 1999 ___**$42,325,591**_____

Please complete Table 4.3.1 for each of your CHIP programs and summarize expenditures by category (total computable expenditures and federal share). What proportion was spent on purchasing private health insurance premiums versus purchasing direct services?

In order to facilitate the transmittal of funds between The NC Division of Medical Assistance (DMA) and the State Employees Health Plan, DMA pays a per member per month fee, allowing the State Employees Health Plan to have an operating budget from which to pay claims. NCHC is a fee-for-service entity. Therefore, the following table reflects the claims payment history of the program not actual payments for premiums.

Table 4.3.1 CHIP Program Type _____

Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Total expenditures	0		0	
Premiums for private health insurance (net of cost-sharing offsets)*	0	• **ENROLLMENT FEE Collections $813,825.11**	0	
Fee-for-service expenditures (subtotal)				
Inpatient hospital services		**$5,445,016**	0	**$4,037,479.36**
Inpatient mental health facility services		**$98,413**	0	**$72,973.24**
Nursing care services		**$6,318**	0	**$4,684.80**
Physician and surgical services		**$5,786,018**	0	**$4,290,332.35**
Outpatient hospital services		**$9,616,161**	0	**$7,130,383.38**
Outpatient mental health facility services		**$880,180**	0	**$652,653.47**

Prescribed drugs		**$2,412,349**	0	**$1,788,756.78**
Dental services		**$2,322,682**	0	**$1,722,268.70**
Vision services		**$227,328**	0	**$168,563.71**
Other practitioners' services		**Hearing Aid Fitting $15,666;foot surgery $23,460; Anesthesia 546,964,;Surgery 2,306,636**	0	**Hearing Aid Fitting $11,616.34; Foot surgery $17,395.59; Anesthesia $405,573.81; Surgery $1,710,370.59**
Clinic services			0	0
Therapy and rehabilitation services		**$190,122 physical therapy $63,620 speech therapy**	0	**$140,975.46 physical therapy; $47,174.23 speech therapy**
Laboratory and radiological services		**$1,022,985 lab,$1,577 radiation therapy, radiology $816,488, pathology $105,257**	0	**$758,543.38 lab; radiation therapy $1,169.35; radiology $605,425.85; pathology $78,048.07**
Durable and disposable medical equipment		**$346,592**	0	**$256,997.97**
Family planning			0	
Abortions		0	0	
Screening services		**Hearing $75,137 Immunizations $63,956**	0	**Hearing $55,714.09; Immunizations $47,423.37**
Home health		**$17,895**	0	**$13,269.14**
Home and community-based services		**$45,102**	0	**$33,443.13**
Hospice			0	0
Medical transportation		**$17,080**	0	**$12,664.82**
Case management			0	
Other services		**$105,087**	0	**$77,922.01**

4.3.2 What were the total expenditures that applied to the 10 percent limit? Please complete Table 4.3.2 and summarize expenditures by category.

What types of activities were funded under the 10 percent cap? **Outreach, County Administrative Costs, general administrative costs (DHHS, State Employees Health Plan & Blue Cross and Blue Shield of North Carolina)**

What role did the 10 percent cap have in program design? **We limited our outreach efforts to community activity rather than broadcast media and used the existing infrastructure rather than to create any new bureaucratic systems or positions.**

Table 4.3.2

Type of expenditure	Medicaid Chip Expansion Program		State-designed CHIP Program		Other CHIP Program* _____	
	FY 1998	FY 1999	FY 1998	FY 1999	FY 1998	FY 1999
Total computable share						
Outreach				**$500,000 (State General Fund) +$200,000 from Public Health**		
Administration				**$4,209,511**		
Other_Duke Endowment Grant: Robert Wood Johnson Grant__				**$300,000 Duke $355,986. RWJ**		
Federal share						
Outreach				**$370,750 (SCHIP) + $100,000 from Medicaid**		
Administration				**$3,121,352**		
Other Duke Endowment				**$150,000 (Medicaid match)**		

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

4.3.3 What were the non-Federal sources of funds spent on your CHIP program (Section 2108(b)(1)(B)(vii))

__**X**_ State appropriations
___ County/local funds
___ Employer contributions
__**X**_ Foundation grants **NCHC received grants from the Robert Wood Johnson Foundation for testing successful outreach strategies ($355,986.) and from the Duke Endowment for outreach to minority populations ($150,000).**
____Private donations (such as United Way, sponsorship)
__**X**_ Other (specify) **Enrollment fee**

4.4 How are you assuring CHIP enrollees have access to care?

4.4.1 What processes are being used to monitor and evaluate access to care received by CHIP enrollees? Please specify each delivery system used (from question 3.2.3) if approaches vary by the delivery system within each program. For example, if an approach is used in managed care, specify 'MCO.' If an approach is used in fee-for-service, specify 'FFS.' If an approach is used in a Primary Care Case Management program, specify 'PCCM.'

Table 4.4.1			
Approaches to monitoring access	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
Appointment audits			
PCP/enrollee ratios			
Time/distance standards			
Urgent/routine care access standards			
Network capacity reviews (rural providers, safety net providers, specialty mix)			
Complaint/grievance/ disenrollment reviews		**DMA monitors informal complaints and grievances and works in conjunction with the State Employees Health Plan as a plan manager to correct/resolve if possible any problems as they arise. DMA is in the process of conducting a survey of those who failed to reenroll in the program during ffy2000 as part of its effort to determine customer satisfaction with the program.**	
Case file reviews			
Beneficiary surveys		**The Division of Medical Assistance has contracted with the University of North Carolina at Chapel Hill to conduct access to care surveys of a sample of beneficiaries.**	
Utilization analysis (emergency room use, preventive care use)		**Through Blue Cross/Blue Shield files, DMA is monitoring utilization in a variety of areas including emergency room, preventive care, and visits by certain diagnostic codes to monitor access to special needs services**	

Other (specify) Special Needs Children_		**The task of monitoring and evaluating access to care for children with special health care needs in the fee-for-service structure of NC Health Choice for Children is challenging. Unlike managed care arrangements, children are not necessarily linked to a medical home. Families can choose their own doctors and may not choose one that is board-certified or who has pediatric experience.** **Because the core benefit package in NC Health Choice for Children is very rich, most children with special health care needs have their health needs fully met within the core plan and may never need wraparound services. We monitor service utilization of children using a list of approximately 100 selected ICD-9 codes. Preliminary data runs indicate that 11 % of children enrolled in Health Choice have one of the diagnoses on the list and can be considered to have a special health care need, a figure that is in line with most national prevalence estimates. Using this mechanism we have looked at inpatient and outpatient services by income level. In ffy 2000 the assessment plan will be refined to reflect utilization by diagnosis and more detailed prevalence data.**	
Other (specify) _____			
Other (specify) _____			

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

**

4.4.2 What kind of managed care utilization data are you collecting for each of your CHIP programs? If your State has no contracts with health plans, skip to section 4.4.3. **North Carolina has no contracts with health plans.**

Table 4.4.2			
Type of utilization data	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
Requiring submission of raw encounter data by health plans	___ Yes ___ No	___ Yes ___ No	___ Yes ___ No
Requiring submission of aggregate HEDIS data by health plans	___ Yes ___ No	___ Yes ___ No	___ Yes ___ No
Other (specify)__	___ Yes ___ No	_ Yes ___ No	___ Yes ___ No

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

4.4.3 What information (if any) is currently available on access to care by CHIP enrollees in your State? Please summarize the results**. Currently only BCBS utilization records are available. The Sheps Center survey that is underway is described in 4.4.4**

4.4.4 What plans does your CHIP program have for future monitoring/evaluation of access to care by CHIP enrollees? When will data be available?

A study is underway at the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill that will provide information on access to care by NCHC enrollees. Study results will be available in the spring of 2001. The study consists of two waves of surveys. The first wave, which has already been completed, asks parents of children newly enrolled in NCHC questions about their child's health status, health care experience, and access to care before enrollment in NCHC, in order to establish baseline data. The second wave, which will be conducted in the early summer of 2000 will resurvey the same individuals about their child's experience since enrollment in the NCHC program. The survey assesses whether or not the enrolled child has a medical home, when the child last had a check up, and emergency room utilization. In addition, questions specifically ask:

- **Were there any times you thought your child needed medical care but she couldn't get it? Why?**
- **Were there any times you thought your child needed dental care but she couldn't get it? Why?**
- **Were there any times a medicine was prescribed for your child but you could not get the medicine? Why?**
- **Were there any times a health care provider refused to care for your child? Why**
- **Were there any times that a health care provider recommended follow-up care for your child that you could not get? Why?**

4.5 How are you measuring the quality of care received by CHIP enrollees?

4.5.1 What processes are you using to monitor and evaluate quality of care received by CHIP enrollees, particularly with respect to well-baby care, well-child care, and immunizations? Please specify the approaches used to monitor quality within each delivery system (from question 3.2.3). For example, if an approach is used in managed care, specify 'MCO.' If an approach is used in fee-for-service, specify 'FFS.' If an approach is used in primary care case management, specify 'PCCM.'

Table 4.5.1

Approaches to monitoring quality	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program
Focused studies (specify)		**Statewide study underway on asthma no results yet**	
Client satisfaction surveys		**Client satisfaction survey underway no results yet**	
Complaint/grievance/ disenrollment reviews		**Disenrollment survey underway on reenrollment eligibles for year 2000**	
Sentinel event reviews			
Plan site visits			
Case file reviews			
Independent peer review			
HEDIS performance measurement			
Other performance measurement (specify)			

Other (specify**) Special Needs**		**The first year was spent developing a quality assurance survey for children with special needs that will be implemented during fall 2000. This will compare children in NCHC, Medicaid and the State Employee Health Plan to assess health status and satisfaction with health care. Survey results will be reportable during ffy 2001.**	
Other (specify) _____			
Other (specify) _____			

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

4.5.2 What information (if any) is currently available on quality of care received by CHIP enrollees in your State? Please summarize the results.

Utilization reports by Blue Cross Blue Shield. We know that our fee for service program utilization is equivalent to the State Employees Plan, a little less than Medicaid.

4.5.3 What plans does your CHIP program have for future monitoring/evaluation of quality of care received by CHIP enrollees? When will data be available?

The Consumer Assessment for Health Plans Survey (CAHPS) will be administered to a random sample of Health Choice enrollees representing all areas of the State. The Division of Medical Assistance has contracted with the University of North Carolina-Charlotte to administer the survey and to analyze and report the survey results. The survey will look at patient satisfaction and access to primary and specialty care among Health Choice enrollees as well as compare patient satisfaction with Medicaid Managed Care Programs and Fee for Service Medicaid. Additionally, the survey will test specific questions regarding the identification of Special Needs Children through a cooperative project between UNC-CH, UMASS, and DMA. A random sample of 1200 Health Choice enrollees from across the State has been extracted. From this sample, UNC-CH will obtain 400 completed surveys needed for a valid study and is necessary due to the challenges of obtaining valid phone numbers and mobility of enrollees at the time the sample is drawn. The questions being tested for the identification of Special Needs children will be used for research purposes only and will not affect the integrity of the survey in determining patient satisfaction. Access to care issues are incorporated into the survey questions. The access questions involve the enrollees' perception regarding the ease/difficulty in getting appointments for routine, sick and specialty care. The results should be completed by fall, 2001.

4.5.4 Please attach any reports or other documents addressing access, quality, utilization, costs, satisfaction, or other aspects of your CHIP program's performance. Please list attachments here.

Blue Cross Blue Shield utilization reports.

SECTION 5. REFLECTIONS

This section is designed to identify lessons learned by the State during the early implementation of its CHIP program as well as to discuss ways in which the State plans to improve its CHIP program in the future. The State evaluation should conclude with recommendations of how the Title XXI program could be improved.

5.1 What worked and what didn't work when designing and implementing your CHIP program? What lessons have you learned? What are your "best practices"? Where possible, describe what evaluation efforts have been completed, are underway, or planned to analyze what worked and what didn't work. Be as specific and detailed as possible. (Answer all that apply. Enter 'NA' for not applicable.)

5.1.1 Eligibility Determination/Redetermination and Enrollment

One of the best aspects of our eligibility determination/redetermination and enrollment processes was our simplified two-page application form (in English and Spanish) which could be mailed in and our ability to accept applications at other non-traditional sites, such as health departments. Our seamless application process for Medicaid and Health Choice allowed by this form worked very smoothly. During ffy 1999 we distributed 1.5 million of these forms. We are currently in the process of refining our reenrollment strategies. We are also currently examining our income verification guidelines for the self-employed to see if changes can be made to simplify these requirements.

5.1.2 Outreach

We are constantly working to refine our outreach program. We have found that 69-70% of our children come from below 150% of the federal poverty level. We attribute that to a number of things: 1) with 44% of the births in North Carolina paid for by Medicaid, we have a large number of customers satisfied with publicly supported health insurance. 2) our first year outreach efforts were concentrated on those who had already been through means tested programs – subsidized day care, WIC, Head Start and other programs. 3) 69% of the enrollees heard about the program through county social services offices who aggressively targeted Medicaid graduates. We have been less successful in reaching out to those over 150% of the federal poverty level. We think the reasons for this include our enrollment fee (the leading cause for denial of applications was failure to pay the enrollment fee), the fact that self-employed people are required to present a year's worth of business records, that in our first year we only began outreach to business. We are currently in the process of refocusing our outreach efforts on business and higher income families to see if we can find ways to make the program more attractive to them. We have found that the grassroots approach to outreach has worked well. A personal contact, especially from an individual or an agency with whom the family already has a high trust level produced the best results. Broad-based media approaches were not very productive.

5.1.3 Benefit Structure

The benefit structure of NCHC for Children is one of its most attractive features from the perspective of both the recipient and provider of services. Our reimbursement rates especially in the area of dental care have prompted more dentists to willingly take NCHC for Children members. The fact that the program mirrors both the benefit plan for state employees and teachers and Medicaid, with additional benefits for dental, vision and hearing makes the benefit structure very successful. Plans for the year 2000 include the addition of a preventive mental health benefit for children – the provision of reimbursement for up to six undiagnosed mental health preventive/early intervention visits so that children may access providers without stigma. The providers advisory panel to the program constantly assesses any change in benefits structure needed for the general population while the Special Needs Commission assesses any needed changes for the Special Needs Population and works to address unique needs of individual families.

5.1.4 Cost-Sharing (such as premiums, copayments, compliance with 5% cap)

Failure to pay the enrollment fee is the number one reason for denial of application – approximately 30% of the applications that are denied are denied for this reason. The program requires a $50 enrollment fee for one child and an $100 fee for two or more children for families above 150% of the federal poverty level. Some thought is being given to finding alternative ways to allow payment rather than the lump sum at enrollment. Copayments have not been a problem in the program No member has yet reached the 5% cap.

5.1.5 Delivery System

NC Health Choice for Children is a traditional indemnity program with any willing provider participation. In general, most members seem very happy with this aspect of the program. We have received calls both from providers and members who are unfamiliar with this approach and the fact that we have no panel of providers. Providers either want to know how to sign on to the program or how to find a specialist to whom to refer a child. Members want to know which doctors or dentists in their community take NCHC patients. We do provide by phone, lists of those who have billed NCHC for service and have explained to providers that if they ever take state employees or teachers they use the same methods for billing. This has been one of the biggest educational processes in this system.

5.1.6 Coordination with Other Programs (especially private insurance and crowd-out)

The NC Health Choice program is working on development of a mechanism to identify children with special needs. The purpose of this identification is three-fold: 1) to identify children who may need additional services not covered under the traditional NC Health Choice service package; 2) to monitor the services received by children with special health needs to ensure that they are receiving appropriate services; and 3) to identify children who may need service coordination and/or emergency respite care. Implementation of the mechanism will be a collaborative effort between the Division of Public Health, the North Carolina Division of Medical Assistance, the NC State Employees Health Plan, and Blue

Cross Blue Shield of North Carolina.

Children with special health needs are currently being identified based on an analysis of ICD-9 codes contained in the Health Choice claims system. However, the NC Commission on Children with Special Health Needs is trying to develop a more comprehensive system based both on self-identification by family members and an analysis of functional status.

Most of the services provided to children with special health needs are covered under the core benefits of the NC Health Choice program. However, North Carolina also has a process to enable children with special health needs to obtain additional services not otherwise covered under the plan. Services for children with special health needs that have been rejected by the traditional NC Health Choice program are reviewed by the Medical Director for the Children and Youth Branch of the Women's and Children's Health Section for possible coverage. From October 1, 1998 to January 1, 2000, the Children's and Youth branch has covered $162,872.58 (as of January 1, 2000) in additional services for children with special health needs. Such services include: augmented wheel chairs, programmable hearing aids, and therapy services (speech, occupational and physical therapy) that exceed traditional coverage limitations.

5.1.7 Evaluation and Monitoring (including data reporting)

North Carolina has worked hard this year to get our data reporting up to date. The impact of Y2K and a number of natural disasters hindered some of our efforts (this will be particularly noticeable in the ffy2000 report when the three hurricanes and subsequent flooding in September, 1999 severely impacted several areas of our program, particularly our computer systems). The fact that NCHC for Children is designed as a bridge between Medicaid and the Division of Information Systems and EDS Federal and the Blue Cross Blue Shield system made this portion of the program particularly challenging. Assuring that data crossed computer systems intact and that competing computer systems conversed required a great deal of administrative time, effort and money. For example, the need to divert resources to Y2K and subsequently to HIPPA reporting requirements have thrown a number of desired reports out of sequence or delayed them for months at a time. Despite these problems, the program is being monitored and needed corrections are being made on a timely manner. In an ideal world now that there has been delinking of Medicaid and welfare, there should be one insurance-based computer system allowing program flexibility and rapid response. We are not there yet.

5.1.8 Other (specify)

5.2 What plans does your State have for "improving the availability of health insurance and health care for children"? (Section 2108(b)(1)(F))

Currently the administration is considering an expansion of our S-CHIP plan to 300% of the federal poverty level with a full cost buy-in available over 300 %. Here is a short description of the concept:

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1. **Expand NCHC for Children to 300% of poverty using graduated premiums between 200% to 300%. The current benefits package, delivery system, reimbursement rates and enrollment system would remain in place. Allow families above 300% to buy in at full cost.**

2. **Waive the waiting period requirement for children with special health care needs as defined in the children's health insurance legislation. While the rationale for the waiting period is to deter crowd out, the heaviest burden of the rule falls on families who have made the greatest sacrifice to purchase high-priced, inadequate insurance for their special needs children. These families cannot sustain the risk of leaving their vulnerable children uncovered for even 60 days for fear of incurring a catastrophic medical bill.**

3. **Make Medicaid and NCHC seamless. All publicly sponsored children's health insurance programs to have one name with one Swipe Card. Reimbursed rates, provider payments and funding sources would be back office electronic information management activities. Patients and families would not need to know which funding source paid their bill. The Swipe Card would carry that information for the providers and payers. Benefits and providers would be the same. All children would have access to a comprehensive publicly sponsored health insurance program, or the private insurance of their choice.**

In addition, on July 1, 2000 NCHC for Children will begin offering a preventive mental health/early intervention benefit that will allow up to six undiagnosed mental health visits annually, effectively a mental health check up. The purpose of this benefit is to permit families, schools and health care providers to have a child examined for potentially dangerous mental health problems without attaching the accompanying stigma of a diagnosis.

5.3 What recommendations does your State have for improving the Title XXI program? (Section 2108(b)(1)(G))

The Title XXI program by allowing states to meet the needs of children on a state-by-state basis effectively provides care close to home for working families. The successful future of the program will depend largely on the extent to which flexibility can continue, demands for extraneous paperwork are held to a minimum and restrictive regulations are restrained. Although the concept of the 10% cap for administration is based on a laudable goal, when it comes to start-up costs and the initiation of aggressive outreach, it is unrealistic. Either Congress needs to revisit the 10 % cap or make a provision to

assist states in aggressively marketing both the S-CHIP program and, separately, Medicaid for children. A fully federally financed national media campaign to support publicly financed health insurance including product placement within television programming (e.g. E.R. and Chicago Hope) would be a plus. S-CHIP is not Medicaid and rules for it need to be constructed separately. By the same token, because having a population with health insurance is a positive public policy target, serious consideration needs to be given to affording a publicly sponsored outreach campaign on why it is important to have health insurance for children whatever the family's income level or circumstances. Such a provision would aid recruitment efforts for all public and private health insurance programs. The federal government also needs to allow state-only plans (such as North Carolina) to participate in the Vaccines for Children program.